



On Target

Volume 4

Number 1

April 1997

The Information for State Health Policy Program is a national program supported by The Robert Wood Johnson Foundation



AN INTERVIEW WITH DR. WILLIAM ROPER, MD, MPH Senior Vice President, Prudential Healthcare

At Prudential, Dr. Roper has responsibility for medical management services supporting Prudential

HealthCare's HMO and point-of-service health plans. Previously, Dr. Roper was director of the Centers for Disease Control and Prevention (CDC), served on the senior White House staff, and was administrator of the Health Care Financing Administration (responsible for Medicare and Medicaid). He currently serves as president of the Association for Health Services Research, and is a member of the board of the American Association of Health Plans.

As a physician, the former administrator of the Health Care Financing Administration, former head of the Centers for Disease Control and Prevention, and now a senior vice president of a major managed care organization, what role do you feel information will play in shaping the U.S. health service delivery system?

Measuring health care service delivery has not been done well in the past. Most of the data we have is derived from billing records, but this information tells us little about how services were delivered, or the actual outcome of each service. The diagnosis coding and data collection system used today was designed to provide the information needed for billing and paying for health care, not to provide information on the actual care that was delivered.

Purchasers of health care services are increasingly demanding measurement reports to aid them in seeking out those organizations which provide the best value. These reports and the information they provide will only grow in importance in the face of increasing competition.

A successful implementation of integrated, low-cost methods of maintaining, linking, and accessing patient health care information will create data warehouses for patient populations. With these data warehouses in place, the health care research community will be able to conduct comprehensive population studies that will help improve the quality of care for all Americans.

With the multiple challenges of reduced resources, new reporting requirements that include accountability measures for the provision of health services, and increased responsibilities because of the devolution of federal programs, what types of health data/information should states be collecting and disseminating? What types of priorities should be set for the potential uses of this information? (e.g., monitoring population status, meeting reporting requirements, improving service delivery, affecting public policy, etc.)

Health care information requirements should support the development of national standardized data sets, with due attention to issues of privacy and confidentiality. Data collection methods among the states could vary (as states seek out the lowest possible cost methods while maintaining basic data integrity and reliability) but the validation approaches for the standardized data sets should be the same.

The measurement programs of the National Committee for Quality Assurance (NCQA) are a good start. The NCQA has defined measurements of health maintenance standards, availability of care, satisfaction, and utilization.

There would be grave concerns if all 50 states tried to invent their own systems of coding and measurement. Precious resources would be wasted trying to do

(continued on page 6)

IN THIS ISSUE

Multiple Efforts
But Single Goal
page 2

Working Together
page 3

Data Linkages
page 4

National Program Committee

Alan B. Cohen, Sc.D.
Boston University
School of Health Care
Management

Randolph A. Desonia
National Governors' Association

M. Susan Marquis, Ph.D.
The RAND Corporation

Nelda McCall
Laguna Research Associates

Jeffrey C. Miller
Northwestern University
Medical School

Allan Noonan, M.D.
U.S. Public Health Service

Charles H. Rothwell
National Center for
Health Statistics

Sarah C. Shuptrine
The Southern Institute on
Children and Families

Gloria R. Smith, Ph.D.
W.K. Kellogg Foundation

Steven L. Taylor, D.S.W.
The American Red Cross
Greater New York

InfoSHP Grantees

ARKANSAS
Department of Health

CALIFORNIA
Health and Welfare Agency

MISSISSIPPI
Division of Medicaid

NEW YORK
Department of Health

NORTH CAROLINA
Department of Environment,
Health and Natural Resources

SOUTH CAROLINA
State Budget and
Control Board

WISCONSIN
Department of Health
and Social Services

CHIPP FOCUSES ON MULTIPLE EFFORTS BUT A SINGLE GOAL: To Improve Health Data Access and Dissemination

As the demands for health data and information increase from all sides, the California Information for Policy Project (CHIPP) has worked hard to stay abreast of current developments in both health care and information exchange. CHIPP has remained on the “cutting edge” as the various problems and concerns related to accessing, collecting, and using health data are resolved. How has it managed to do so? At the heart of CHIPP’s effort to remain out in front in the health information arena, is its infrastructure of advisory committees and working groups that consist of representatives from a variety of public and private agencies. The individuals who serve on these committees provide CHIPP with the leadership and expertise necessary to address key issues such as the development of standards for data integration and enhancement of health data access and dissemination

From the start, these individuals recommended that CHIPP focus its attention on four projects: the uniform definition of core data elements; the linkage of databases; a health information fact book; and an inventory of health information databases. CHIPP project director Mike Kassis explains why these four projects were selected:

“These efforts were identified as having the greatest utility for the greatest number of people in the state by our advisory committee. In addition, the committee agreed that they would be the easiest steps to take as we head in the direction of developing fully integrated databases. In many ways, these projects are a stepping stone toward that ultimate goal. In particular, committee members felt that the a database inventory was a critical interim step that would both increase awareness of and access to existing data resources.”

Each of the four CHIPP projects is highlighted below.

Defining Core Data Elements

CHIPP worked with several other organizations in the state to define a uniform set of core data elements to serve as a minimum data set standard. Core data elements are particular pieces of information — such as an individual’s date of birth, birth name, and gender — that are common to all databases and similarly formatted within the databases. (Please see Figure #1) The core data elements, which were formally approved by CHIPP’s Health Data Coordinating Council and Steering Committee, were subsequently mandated

for use in all California Department of Health Services (CDHS) data programs by June 1988 through an executive order by the Director of CDHS.

CORE & CONFIRMATORY DATA ELEMENTS

Core Elements	Confirmatory Elements
• John Doe (Birth Name)	• Any County, Calif. (County of Residence)
• 04-22-97 (D.O.B.)	• — — — (Client’s Alias)
• Male (Gender)	• Andrew Doe (Father’s Name)
• Jane (Mother’s First Name)	• Jane Smith (Mother’s Maiden Name)
• Any County, California (Place of Birth) (or Other State Name, or Country if out of USA)	• Other Client Numbers (Other Identifiers)
	• 123-45-6789 (S.S.N.) (Optional)
	• 12345 (Zip of Client Residence)

Figure #1

The core data elements have been piloted in Orange, San Diego, and Marine Counties to link databases from various government sponsored categorical programs for registration and client case management. According to Harold Tuck, MBA, information systems manager for the County of San Diego Department of Health, the use of core data elements that are uniformly defined paves the way for linking a variety of separate databases.

“If everyone collects the same 12 data elements the same way, you can begin to match records from file to file so you avoid duplication of client records,” Tuck said. “In addition, if the data elements — such as client name or date of birth — are all coded the same way there’s no need to go through the extra work of converting elements as you link the files.”

After the core data elements form a virtual individual identifier, confidential elements such as name, birth date and social security number are stripped from the resulting linked data set to preserve an individual’s identity. The use of these elements are strictly for the linkage process increasing the quality of the link. They are not used to specifically identify any individual or make any personal contacts.

Linking Databases

CHIPP has moved beyond defining core data elements to actually linking databases. Their initial effort in this area was to link hospital discharge data to California’s vital statistics death and birth files. The outcome of the birth/discharge and death/discharge linkage

(continued on page 7)

EDITORIAL

by Ira Kaufman

ADMINISTRATIVE
SIMPLIFICATION?:
Health Outcome Studies
Meet Privacy Issues

This March, the President appointed his Managed Care Quality Commission.

Only months earlier, Congress enacted and the President signed "The Health Insurance Portability and Accountability Act of 1996," also known as the Kennedy-Kassebaum bill. The latter will provide us with the data standards to make the task of former possible. The Kennedy-Kassebaum legislation includes an "Administrative Simplification" section, an attempt to bring closure to the same issue (sharing information while protecting privacy) that has confronted us since the early courtship of medicine and computers. These two efforts — the commission and the legislation passed in its wake — require the nation to address:

- How can we identify truly effective health care without coordinating information from multiple sources at the individual patient level?
- How can we avoid violating individuals' rights to privacy in the process?

The commission will need data standards to facilitate the linking of data on individuals and providers to determine how to improve the health care system. Fortunately, the law mandates their development. But the law does not require the development of a process to define what health information should be collected and how it should be obtained. I believe we need a process that requires stakeholders — the providers, payers, purchasers, and consumers, as well as state and federal government — to develop standards for a fixed time interval and then update them on a regular cycle. Why? Because both needs and technology change.

However, what is paramount with any electronic health data exchange system is the definition of uniform identifiers for providers, plans, and "anonymized" individuals so the privacy of the individual is protected as information is shared among data users. Any rules developed for this Act must define medical privacy and develop privacy safeguards for both individual patients and individual practitioners. But privacy cannot be a single-definition absolute: practitioners need to be able to quickly access information and share it; health departments need to access particular kinds of information immediately when faced with contagious disease outbreaks or child abuse cases. The rules must address the varying needs for and uses of the data.

And a final caveat. The rules recommended by DHHS, and reviewed and finally approved by Congress must leave room for the current state laws that address local issues. They must also facilitate states' efforts to take responsibility for and assure accountability to its citizens.

WORKING TOGETHER: Synergy In Action

A unique collaborative effort is now underway in California because of the California Health Information for Policy Project's (CHIPP) interest in and success with linking key health care data sets. This partnership brings together three major health care-related entities: the Pacific Business Group on Health (PBGH), the University of California at Davis (UCD) School of Medicine, and CHIPP. These organizations are working together to produce a linked file containing data from the California Birth Statistical Master file (which contains information on all infants born in the state) and the Hospital Patient Discharge Data file for 1994 (which contains information on all patients discharged from the state's hospitals in 1994). The goal of the partnership is to produce an information-rich database that will meet the unique needs of each organization and benefit many others — including researchers, policy makers, and service organizations — with similar interests.

"This is certainly a case where the whole is greater than the sum of the parts," explained Mike Kassis, CHIPP project director. "Each entity in this partnership has its own individual need for the linked database that will be realized by our efforts. Yet we all clearly recognize that by working together we can each reach our goals more quickly and efficiently, and produce a superior database that will be of use to many other organizations and individuals as well."

Who's Involved: A Closer Look at the Partners

CHIPP's objective for the linked data set is broadbased — the program seeks to create a public-use file that will assist policy makers, health program administrators, and researchers in their monitoring and analysis efforts. The methodology for the data linkage and the resources will ultimately be brought under CHIPP's umbrella, allowing CHIPP to replicate the linkage process for future years of data.

The Pacific Business Group on Health, a large business coalition in California, is one of the most active employer coalitions in the country. It represents approximately 2.5 million employees, dependents, and retirees, with \$3 billion in annual health care expenditures. Its membership includes 33 private and public sector purchasers, each with at least 2,000 employees in California who are eligible for benefits. In 1994, PBGH employers formed a Negotiating Alliance to collectively negotiate with California HMOs for a standard-



ized benefit package emphasizing both price and quality. PBGH also conducts a number of studies to measure and ultimately improve quality at all levels of the health care system — including health plans, hospitals, and physician groups. These projects are largely funded by a Quality Improvement Fund established by PBGH member companies and private foundation grants. The majority of PBGH's quality studies focus on high cost/high volume areas. That's why they tend to focus on "babies and hearts" explained Anne Castles, a PBGH project manager. "These are areas that affect most of our members."

It is specifically in this arena of quality measurement that PBGH plans to use the linked birth-discharge data file. PBGH intends to examine the quality of care provided to mothers and newborns in the postpartum period. Specifically, PBGH will look at the relationship between maternity lengths-of-stay and the rate of re-admission for infants for all hospitals in California that perform deliveries.

(continued on page 5)

DATA LINKAGES YIELD RICH DATA FOR USERS: Joining Databases to Create “Super” Databases

In the language of database linkage, one plus one does not equal two. It doesn't really even equal one. Instead, when two separate but relevant databases are linked, you get a new, “super” database — one that provides the user with richer, more accurate, and more detailed information.

“Linked databases just make a tremendous difference in the kinds of things we are able to evaluate with regard to access to care and outcomes, commented Dr. Tom Nesbitt, MD, MPH, of the University of California at Davis (UCD) Medical School Department of Family Medicine. “For example, because we have linked discharge and birth certificate files we can trace infants back to their mothers and look at how the shorter hospital stays mandated by managed care organizations affect outcomes. We can do this — and do it easily — only because the two databases are linked.”

CHIPP's data linkage activities continue on a number of fronts. Eventually, CHIPP hopes to produce data sets that will be available for use by the general public (as well as researchers, policy makers, and others) that join death, birth, cancer and Medicaid data with California's hospital discharge data. Public use data sets will be void of any confidential data elements, as prescribed by law, and any other data elements that in combination may risk a confidentiality breach will be stripped from the record.

There are many benefits to the linked databases for many different parties:

- Researchers, program administrators and policy makers can now access a linked file through a single request to one agency, rather than sifting through a maze of departments and agencies to find the databases they need. Also, they do not have to use additional resources to develop linkage algorithms because this has already been done for them — saving both time and money. In

addition, data consistency is assured because a single linked file is available to all users, rather than users accessing similar information from multiple files.

- The linked databases provide medical researchers with a wealth of health and health-care related information that will simplify the data collection process for their studies. Several research studies have already been completed using the linked birth/discharge data sets. They include examining the risk factors associated with shoulder dystocia in newborns; characterizing and comparing the pregnancy complications that occur in twin, triplet, and quadruplet gestations; determining the incidence, risk factors, and pregnancy outcomes in patients with placenta previa; and examining the risk factors associated with brachial plexus injury in a large population-based study. Over time, these studies and others can be replicated to provide a longitudinal perspective.

- The Cancer Registry data and discharge data linkage has provided a means to verify California Cancer Registry (CCR) case-finding methodologies, improve the calculation of survival following diagnosis and treatment for cancer, and assess other concurrent health conditions that may affect treatment patterns, such as breast cancer treatment.

- The linkage of California's death certificate data with the discharge data has provided a valuable source of data for analyzing critical policy and program questions regarding the treatment patterns, effectiveness, and associated costs of specific types of injuries and conditions. For example, researchers and physicians can evaluate the outcome of using forceps during the delivery of infants weighing over 600 grams or using forceps for a delivery in which there is shoulder dystocia.

- Several studies are underway using the linked data files that address questions specific to the effects of managed care. One study examines

postpartum hospital stays and outcomes for particular HMOs; another compares hospitalization rates, especially for preventable conditions, for those enrolled in HMOs and those receiving services through a fee-for-service program. Eventually, CHIPP hopes to begin working on linking hospital discharge data with California's Medicaid eligibility data and managed care encounter data to review and compare outcomes and quality of care by health plan.

Hand-in-hand with its work on linking databases and defining core data elements, CHIPP is addressing confidentiality and data security issues. For example, in the death certificate/discharge linkage, common elements occur in the files; however, some of these elements are confidential in the hospital discharge file. The patient's date of birth, admission date, discharge date, and social security number are all considered confidential in the discharge data, but they are publicly available though the death files. CHIPP recently developed a review process that includes safeguards to prevent the release of confidential patient information. The data elements considered confidential in the discharge data are obvious and can be immediately addressed, but it is likely that the linked file will create new combinations of elements that may inadvertently reveal a patient's identity. CHIPP and others involved with data linkage work are very excited about its potential.

California expects to continue its efforts in this area even after the close of The Robert Wood Johnson Foundation Information for State Health Policy (InfoSHP) grant. In fact, eventually the Office of Statewide Health Planning and Development — the entity within the state responsible for the security and dissemination of the linked data sets — intends to add the human and other resources to complete the data linkages internally rather than rely on the services of outside consultants.

This publication is prepared by the National Program Office of the Information for State Health Policy Program under a grant from The Robert Wood Johnson Foundation. The purpose of the program is to strengthen state data infrastructures as well as facilitate interaction, discussion, presentation, and the dissemination of data to health policy makers for decision making.

Ira R. Kaufman
PROGRAM DIRECTOR

Denise A. Davis
DEPUTY DIRECTOR

Karin B. Gillespie
EDITOR

Falco & Falco
DESIGNERS

We would like to thank Dr. William Roper, Dr. Tom Nesbitt, M.D., MPH, Beate Danielson, PhD., and Ms. Teddy Milder for their contribution to this effort. In addition, Mr. Michael Kassis and the staff of the California Health Information Policy Project within the office of Statewide Health Planning and Development, under the directorship of Dr. David Werdegard, in the State of California provided valuable assistance to us in the preparation of this issue of *Health Policy On Target*.

To receive additional copies, please write:

Information for State Health Policy Program
UMDNJ, New Jersey's University of the Health Sciences
Department of Environmental and Community Medicine
The Robert Wood Johnson Medical School
675 Hoes Lane
Piscataway, NJ 08854-5635
(908) 235-4548
FAX (908) 235-4569

Synergy in Action

(continued from page 3)

“This linked database will allow us to undertake an important study of the relationship between early postpartum discharge and the rate of hospital readmissions that just would not be possible if we had to deal with a number of separate databases,” commented Castles. “You just can’t capture all the variables that may affect readmission without both files.”

The Department of Family Practice in the UCD School of Medicine is interested in using the linked database to study quality of care issues as well, noted Dr. Tom Nesbitt, MD, MPH, who is a physician in UCD’s Department of Family Medicine and a Robert Wood Johnson Foundation Generalist Physician Faculty Scholar.

“This partnership and its effort to create a linked database was just so timely,” stated Dr. Nesbitt. “My project for the Generalist Physician Faculty Scholars Initiative involves looking at maternal and neonatal services in rural communities to determine if access affects outcomes. In order to do this study, I needed both hospital discharge and birth certificate data. With the new linked database, I have at my fingertips much richer data, much more information, and much more accurate information. In addition, because the linked database brings together two separate databases it is possible to confirm the accuracy of particular information. (See Figure #2) If both data sets indicate that an infant was born at term, then we know this fact with a greater degree of accuracy.”

Dr. Nesbitt is involved in other work outside the bounds of UCD Medical School that will also benefit from the linked database. He is a member of a statewide advisory committee (known as AIM, short for Access to Infants and Mothers) that works to provide health insurance for women of child-bearing age in California who are uninsured and who do not qualify for Medicaid. (The insurance is paid for by a tobacco tax.) AIM intends to use the linked data file to identify those zip codes that have the greatest number of mothers who are uninsured and who receive the least amount of prenatal care. AIM will then target its marketing efforts to those areas to bring more women into the program.

According to Dr. Nesbitt, other departments at UCD Medical School are also eager to use the linked database. “Our Obstetrics Department is already using the linked file to look at particular kinds of birth injuries and their associated risk based on infant birth weight; the use of forceps during delivery; prenatal care; and certain health conditions of the mother, such as diabetes.”

Partnership's Efforts Will Benefit Many

Each player in this collaborative venture has a specific objective for the linked data file. Yet, the fruits of their labor — the linked birth-discharge database — will benefit policy makers, researchers, health care program managers, and the general public across the great state of California.

“Ultimately, the information that results from these and other studies that use linked databases will affect positive change in the state’s continually evolving health care delivery system,” noted Kassis.

Why linking the three data sets?

Vital Statistics Data

- Sociodemographics
- Prenatal Care
- Mortality Outcome
- Other Birth Outcomes

Hospital Discharge Data

Variables for...

- Demographics
- Diagnosis Outcomes
- Health Service Resource Use
- Procedure Outcome

Figure #2

Roper Interview

(continued from page 1)

essentially the same work 50 different ways — with little, if any, additional gain.

What role should insurance companies and/or managed care corporations play in the development of standards of care and measures of quality, and improving access to care?

Effective changes can be made to the health care system if measurements pinpoint the status of a particular health condition, identify specific things to change in order to improve health, and measure the result of the change — in a process of continuous improvement.

Managed health care organizations serve as the most effective linchpin for this effort because of their responsibility for providing continuity of care. As integrated systems of care, they are intimately involved in providing access to care, clinical care guidelines, and measures of quality, as well as setting goals for true improvements in health outcomes.

In general, the usefulness of a managed care information system is measured by the amount of overall system integration — that is the ability of the information system to fully integrate clinical, financial, and other operating data. What role should managed care organizations play in improving state data systems so that they fully reflect “the big picture” and are able to provide the data to answer the questions raised by various groups? How could this be accomplished?

Because insurance companies and managed health care organizations typically bring together the various parts of the health care system, they are positioned best to integrate all of the data from these parts, and provide the “big picture” answers. Emphasis on information standards would appear to be the best way to move health care information systems forward, reducing the need to expend so much effort in the translation of data from one system’s nomenclature to another, or manually gathering information off of paper reports and records.

The emergence of managed care has led to the development of tighter budgets within states and attempts to improve efficiency on various levels. It has also created unlikely or strange bedfellows as public-private partnerships form among managed care executives, business leaders, and community advocates. In your opinion, have these partnerships created opportunities to improve the health of communities and meet their social service needs? How?

It is a positive step anytime leading organizations join forces to help solve social problems. For example, the Prudential Center for Health Care Research formed a unique public-private partnership in Tennessee to explore mechanisms for increasing prenatal care for women in the state’s Medicaid program. Increased access to care benefits the mothers-to-be, and provides newborns a chance at a better and healthier start in life. What we learn in Tennessee will be applied in other areas of the country to help improve the overall health of communities.

In many states, Medicaid Managed Care demonstrations have emerged as the testing ground for system effectiveness. In the past, health care services for the Medicaid population and the working poor have been provided by public health facilities and providers. As managed care organizations increasingly fill this role, what steps will they take to assure positive outcomes for these populations with special needs? Will public health providers and community advocates also play a role in this?

Managed care allows for a more systematic approach to the needs of the Medicaid population. It is in the best interest of managed care organizations to address these needs if we are to improve quality and decrease costs. We provide incentives for prenatal care, outreach to patients to improve follow-up, and assistance with other social service needs. In addition, we produce measures of our performance, unlike the fee-for-service sector.

In your opinion, are there incentives for managed care organizations to become involved in health education and/or health promotion within the communities they serve? Is there a cost-benefit to this activity?

Certain health promotion and disease prevention efforts, such as

pediatric immunization, have been demonstrated to be cost-effective. However most health promotion efforts are not cost-effective in the short-term — at least not in the strict sense of the word. In the longer run, health promotion leads to healthier people, which means less cost overall to the health care system. Rather than just focus on business terms such as cost-benefit and return-on-investment, it is important for managed care organizations to focus on doing the right thing for the communities they serve. For example, a MCO is likely to offer programs to address smoking cessation, weight management, and other preventive services. Managed care organizations do so not because they expect to see a return on their investment, but because they recognize that these activities are integral components of preventive care and improvement in health of communities. We provide these programs because we are committed to the communities we are part of and to improving the health of their citizens.

What challenges will managed care organizations face as we head toward the Year 2000?

Our challenges include gathering more complete clinical information in a cost-effective manner; establishing more direct and real-time interactions with physicians (e.g., reminders for preventive services and delivery of clinical information and treatment guidelines); improving access while containing costs; improving the health of the populations we serve; and expanding our focus to include other benefits to employers (e.g., lower workers’ compensation costs and additional services not now covered by some plans, such as routine flu vaccines).

Managed health care organizations face unprecedented regulation at the state and federal levels. If this regulation is improperly carried out, we could see the erosion of a sector of the health care delivery system that finally offers controlled costs, enhanced quality, and the real promise of collecting and using data to advance the health of the American people.

CHIPP FOCUS *(continued from page 2)*

is several new and richer databases that provide more clinical and demographic information. Specifically, these data sets enhance the user's insight into risk factors, resource allocation, and quality of care. CHIPP plans to continually replicate and improve the linkage methodologies to create longitudinal data for on-going trend analyses, health policy decision making, and condition-specific studies.

Beate Danielsen, PhD, worked closely with CHIPP on the data linkage project. She has this to say about the work that went into producing the linked files and the final outcome: "The actual linkage process was difficult largely because of the sheer size of the databases. For example, the discharge database includes almost 600,000 records per year. Linking the databases was a very exploratory process. We had to determine which variables to use and what order to use them in. The bottom line is we had to get to know two very large databases very well — and that takes time."

"But the results are promising," Danielsen continued. "As researchers and policy makers, we are now able to make some very powerful statements about infant health in the state — by looking simultaneously at birth records, hospital discharges, and death information. Furthermore, we can begin to relate measures of infant health to socio-demographic background. It is a good thing that we have these new measures of infant health because the infant death rates in the state are now so low that they can no longer serve as a valid measure of comparison." (See Figure #3)

An Overview of Californians' Health: The Fact Book

CHIPP's objective with the California Health Fact Book is to put meaningful health data and information at the reader's fingertips. In a clear, concise, and mostly graphic-format, the Fact Book depicts a variety of health status indicators by geographic region, race/ethnicity, socio-economic level, and various other stratifications of the state population. The Fact Book was created using data from many differ-

ent databases within the departments of the Health and Welfare Agency, and it illustrates that data collected by the state can be an effective tool for enlightening state and local government policy makers, schools and universities, communities, and the general public on the health status of the California population.

The California Health Policy and Data Advisory Commission intends to use the Fact Book as the centerpiece of the health economics curriculum they are currently developing for high school seniors across the state.

"It is just a wonderful publication and one of the most useful documents ever developed by the California state government," noted Jacquelyn Paige, MA, executive director of the Commission. "The Fact Book so succinctly profiles the health of different sectors of the California population that it will help heighten students' awareness and indirectly spark thought on their part about their future as it relates to access to health care. Kudos to The Robert Wood Johnson Foundation for supporting an initiative that takes health data and transforms it into truly relevant and useful health information."

The Health Information Database Inventory

In a related effort to increase access to health information, CHIPP created the California Health Information Database Inventory. The Inventory brings together — in one central file — information on over 125 health databases managed by the various departments of the Health

and Welfare Agency. Inventory users are able to identify the data available for their particular needs without individually navigating the maze of inter-departmental databases within the Agency.

Teresa Nuno, Director of Policy and Program Development for the Multicultural Area Health Education Center in Los Angeles, describes the Inventory as a real boon for her organization.

"Accessing state data on health is one of our major foci," commented Nuno. "We were selected as one of six sites across the country by the Carnegie and Ford Foundations to establish a Youth Health Policy Center. So we are in the process of building the internal capacity to develop policy. And much of this involves collecting data. After hours of detective work spent on the phone with a multitude of state offices and departments tracking down various databases — a task that was grueling, daunting, and extremely frustrating at best — I was just delighted to learn about the Inventory. It is so timely for us. With its head start, I see great potential for CHIPP to become California's 'Library of Data' — the consolidated focal point in the state for health information or assistance with locating it."

CHIPP will continue to expand and update the Inventory, adding information from the federal government and the private sector. For those who are interested, the Inventory is available on CHIPP's World Wide Web home page at: <http://www.chipp.cahwnet.gov>.

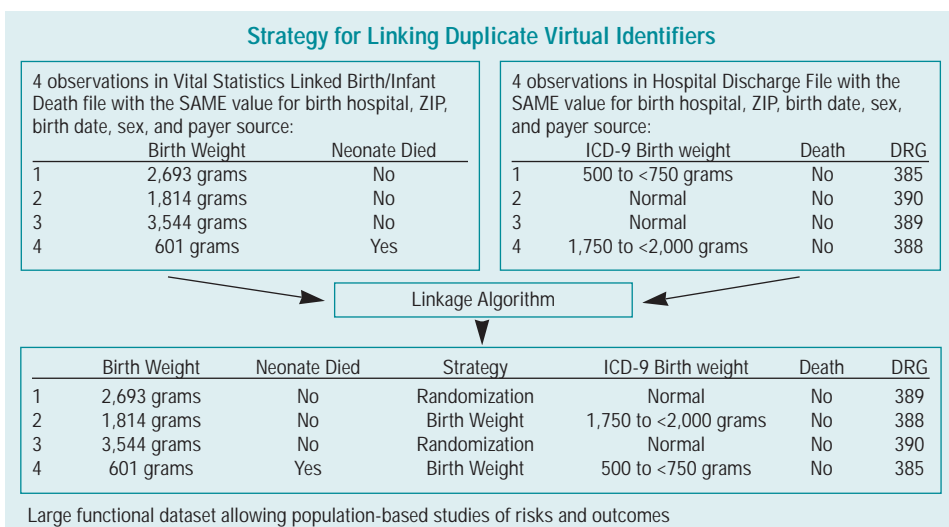


Figure #3

Relevant Cyberspace Sites

Center for Health Care Strategies, Inc. (CHCS)

<http://www.chcs.org/>

A non-profit, non-partisan policy and resource center affiliated with the Woodrow Wilson School of Public and International Affairs at Princeton University. It serves as the National Program Office for two national initiatives of the Robert Wood Johnson Foundation: Medicaid Managed Care Program and Building Health Systems for People with Chronic Illnesses.

The National Health Information Resource Center (NHIRC)

<http://www.nhirc.org/home.html>

A clearinghouse and communications hub about health information systems and data, it was designed to provide access to the resources needed to build and use health information systems and data. It also provides a forum for individuals to share expertise and experience with other NHIRC users by adding to its databases and participating in discussions.

Social Statistics Briefing Room (SSBR)

<http://www.whitehouse.gov/fsbr/ssbr.html>

The purpose of this service is to provide easy access to current Federal social statistics. It provides links to information produced by a number of Federal agencies. All of the information included in the Social Statistics Briefing Room is maintained and updated by the statistical units of those agencies.

Information for State Health Policy Program (InfoSHP)

<http://www2.umdj.edu/shpp/homepage.htm>

Established by the Robert Wood Johnson Medical School Department of Environmental and Community Medicine, the Information for State Health Policy Program web site promotes information sharing between the state grantees under the program. This web site is also a vehicle for states to share experiences and insights into the changing health care arena, and to display new techniques developed by and for state health policy makers and other users of state health data. The Information for State Health Policy Program helps states strengthen their health statistics systems to support state policy making, program development, and management purposes. This site was developed as part of a grant from The Robert Wood Johnson Foundation.

Information for State Health Policy Program
UMDNJ, New Jersey's University of the Health Sciences
Department of Environmental and Community Medicine
The Robert Wood Johnson Medical School
675 Hoes Lane
Piscataway, NJ 08854-5635

NON-PROFIT ORG.

U.S. Postage

PAID

Permit No. 44

Piscataway, NJ



E:mail

infoshp@umdj.edu